5711 Sarvis Ave., Suite 402
Riverdale, MD 20737 .

110 Irving St. NW Suite 1A1
Washington, DC 20010

WASHINGTON EYE INSTITUTE

PATIENT REGISTRATION FORM

PLEASE PRINT LEGIBLY

PATIENT INFORMATION

Patient's Name _____, _____ _____
LAST NAME FIRST NAME MIDDLE NAME

Date _____ **Social Security #** _____--_____--_____ **Birth Date** _____ **Sex** _____

Address _____ **Apt. #** _____

City _____ **State**_____ **Zip**_____

Marital Status _____ **Student Y/N** _____ **Employer/School Name** _____

Home Phone # (_____**)**_____ **Work Phone #(**_____**)**_____ **Cell Phone #(**_____**)**_____

Preferred phone number to contact you: ☐ **Home** ☐ **Cell** ☐ **Work** **E-mail address**_____

Emergency Contact Person_____ **Phone# (**_____**)**_____ **Relationship**_____

Primary Care Physician / Family Physician_____ **Phone # (**_____**)**_____

How did you hear about us? Please write full name if known:

☐ **Referring Doctor:** _____ ☐ **Phone Book / Advertisement:** _____

☐ **Friend / Relative:** _____ ☐ **Other:** _____

INSURANCE INFORMATION

Primary Insurance Carrier _____

Policy / Member ID # _____ **Group #** _____

Policy Holder's Name _____ **Policy Holder's Date of Birth**_____
(If different from Patient)

Secondary Insurance Carrier _____

Policy / Member ID # _____ **Group #** _____

Policy Holder's Name _____ **Policy Holder's Date of Birth**_____
(If different from Patient)

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the office of Washington Eye Institute to apply for benefits on my behalf for covered services rendered. I certify that the information I have provided regarding my health insurance is correct. I authorize the release of necessary medical information to my insurance company in order to determine the benefits to which I am entitled. I will be responsible for the remainder of my bill not covered by my health insurance.

I understand that Medicare insurance does not reimburse for vision examinations.

_____ _____
Signature of Patient or Guardian **Date**